

(B) *Automatic enrollment.* An employee or related individual is treated as not enrolled in an eligible employer-sponsored plan for a month in a plan year or other period for which the employee or related individual is automatically enrolled if the employee or related individual terminates the coverage before the later of the first day of the second full calendar month of that plan year or other period or the last day of any permissible opt-out period provided by the employer-sponsored plan or in regulations to be issued by the Department of Labor, for that plan year or other period.

(C) *Examples.* The following examples illustrate the provisions of this paragraph (c)(3)(vii):

Example 1. Taxpayer H is employed by Employer X in 2014. H's required contribution for self-only employer coverage exceeds 9.5 percent of H's 2014 household income. H enrolls in X's calendar year plan for 2014. Under paragraph (c)(3)(vii)(A) of this section, H is eligible for minimum essential coverage for 2014 because H is enrolled in an eligible employer-sponsored plan for 2014.

Example 2. The facts are the same as in *Example 1*, except that H terminates plan coverage on June 30, 2014. Under paragraph (c)(3)(vii)(A) of this section, H is eligible for minimum essential coverage under X's plan for January through June 2014 but is not eligible for minimum essential coverage under X's plan for July through December 2014.

Example 3. The facts are the same as in *Example 1*, except that Employer X automatically enrolls H in the plan for calendar year 2015. H terminates the coverage on January 20, 2015. Under paragraph (c)(3)(vii)(B) of this section, H is not eligible for minimum essential coverage under X's plan for January 2015.

(4) *Related individual not claimed as a personal exemption deduction.* An individual who may enroll in minimum essential coverage because of a relationship to another person eligible for the coverage, but for whom the other eligible person does not claim a personal exemption deduction under section 151, is treated as eligible for minimum essential coverage under the coverage only for months that the related individual is enrolled in the coverage.

[T.D. 9590, 77 FR 30385, May 23, 2012, as amended by T.D. 9611, 78 FR 7265, Feb. 1, 2013]

§ 1.36B-3 Computing the premium assistance credit amount.

(a) *In general.* A taxpayer's premium assistance credit amount for a taxable year is the sum of the premium assistance amounts determined under paragraph (d) of this section for all coverage months for individuals in the taxpayer's family.

(b) *Definitions.* For purposes of this section—

(1) The cost of a qualified health plan is the premium the plan charges; and

(2) The term *coverage family* refers to members of the taxpayer's family who enroll in a qualified health plan and are not eligible for minimum essential coverage (other than coverage in the individual market).

(c) *Coverage month*—(1) *In general.* A month is a coverage month for an individual if—

(i) As of the first day of the month, the individual is enrolled in a qualified health plan through an Exchange;

(ii) The taxpayer pays the taxpayer's share of the premium for the individual's coverage under the plan for the month by the unextended due date for filing the taxpayer's income tax return for that taxable year, or the full premium for the month is paid by advance credit payments; and

(iii) The individual is not eligible for the full calendar month for minimum essential coverage (within the meaning of § 1.36B-2(c)) other than coverage described in section 500A(f)(1)(C) (relating to coverage in the individual market).

(2) *Premiums paid for a taxpayer.* Premiums another person pays for coverage of the taxpayer, taxpayer's spouse, or dependent are treated as paid by the taxpayer.

(3) *Examples.* The following examples illustrate the provisions of this paragraph (c):

Example 1. (i) Taxpayer M is single with no dependents. In December 2013, M enrolls in a qualified health plan for 2014 and the Exchange approves advance credit payments. M pays M's share of the premiums. On May 15, 2014, M enlists in the U.S. Army and is eligible immediately for government-sponsored minimum essential coverage.

(ii) Under paragraph (c)(1) of this section, January through May 2014 are coverage months for M. June through December 2014

are not coverage months because M is eligible for minimum essential coverage for those months. Thus, under paragraph (a) of this section, M's premium assistance credit amount for 2014 is the sum of the premium assistance amounts for the months January through May.

Example 2. (i) Taxpayer N has one dependent, S. S is eligible for government-sponsored minimum essential coverage. N is not eligible for minimum essential coverage. N enrolls in a qualified health plan for 2014 and the Exchange approves advance credit payments. On August 1, 2014, S loses eligibility for minimum essential coverage. N terminates enrollment in the qualified health plan that covers only N and enrolls in a qualified health plan that covers N and S for August through December 2014. N pays all premiums not covered by advance credit payments.

(ii) Under paragraph (c)(1) of this section, January through December of 2014 are coverage months for N and August through December are coverage months for N and S. N's premium assistance credit amount for 2014 is the sum of the premium assistance amounts for these coverage months.

Example 3. (i) O and P are the divorced parents of T. Under the divorce agreement between O and P, T resides with P and P claims T as a dependent. However, O must pay premiums for health insurance for T. P enrolls T in a qualified health plan for 2014. O pays the portion of T's qualified health plan premiums not covered by advance credit payments.

(ii) Because P claims T as a dependent, P (and not O) may claim a premium tax credit for coverage for T. See § 1.36B-2(a). Under paragraph (c)(2) of this section, the premiums that O pays for coverage for T are treated as paid by P. Thus, the months when T is covered by a qualified health plan and not eligible for other minimum essential coverage are coverage months under paragraph (c)(1) of this section in computing P's premium tax credit under paragraph (a) of this section.

Example 4. Q, an American Indian, enrolls in a qualified health plan for 2014. Q's tribe pays the portion of Q's qualified health plan premiums not covered by advance credit payments. Under paragraph (c)(2) of this section, the premiums that Q's tribe pays for Q are treated as paid by Q. Thus, the months when Q is covered by a qualified health plan and not eligible for other minimum essential coverage are coverage months under paragraph (c)(1) of this section in computing Q's premium tax credit under paragraph (a) of this section.

(d) *Premium assistance amount.* The premium assistance amount for a coverage month is the lesser of—

(1) The premiums for the month for one or more qualified health plans in

which a taxpayer or a member of the taxpayer's family enrolls; or

(2) The excess of the adjusted monthly premium for the applicable benchmark plan over $\frac{1}{12}$ of the product of a taxpayer's household income and the applicable percentage for the taxable year.

(e) *Adjusted monthly premium.* The adjusted monthly premium is the premium an issuer would charge for the applicable benchmark plan to cover all members of the taxpayer's coverage family, adjusted only for the age of each member of the coverage family as allowed under section 2701 of the Public Health Service Act (42 U.S.C. 300gg). The adjusted monthly premium is determined without regard to any premium discount or rebate under the wellness discount demonstration project under section 2705(d) of the Public Health Service Act (42 U.S.C. 300gg-4(d)) and may not include any adjustments for tobacco use.

(f) *Applicable benchmark plan—(1) In general.* Except as otherwise provided in this paragraph (f), the applicable benchmark plan for each coverage month is the second lowest cost silver plan (as described in section 1302(d)(1)(B) of the Affordable Care Act (42 U.S.C. 18022(d)(1)(B))) offered through the Exchange for the rating area where the taxpayer resides for—

(i) Self-only coverage for a taxpayer—

(A) Who computes tax under section 1(c) (unmarried individuals other than surviving spouses and heads of household) and is not allowed a deduction under section 151 for a dependent for the taxable year;

(B) Who purchases only self-only coverage for one individual; or

(C) Whose coverage family includes only one individual; and

(ii) Family coverage for all other taxpayers.

(2) *Family coverage.* The applicable benchmark plan for family coverage is the second lowest cost silver plan that applies to the members of the taxpayer's coverage family (such as a plan covering two adults if the members of a taxpayer's coverage family are two adults).

(3) *Silver level plan not covering a taxpayer's family.* If one or more silver

level plans for family coverage offered through an Exchange do not cover all members of a taxpayer's coverage family under one policy (for example, because of the relationships within the family), the premium for the applicable benchmark plan determined under paragraphs (f)(1) and (f)(2) of this section may be the premium for a single policy or for more than one policy, whichever is the second lowest cost silver option.

(4) *Family members residing at different locations.* [Reserved]

(5) *Plan closed to enrollment.* A qualified health plan that is not open to enrollment by a taxpayer or family member at the time the taxpayer or family member enrolls in a qualified health plan is disregarded in determining the applicable benchmark plan.

(6) *Benchmark plan terminates or closes to enrollment during the year.* A qualified health plan that is the applicable benchmark plan under this paragraph (f) for a taxpayer does not cease to be the applicable benchmark plan solely because the plan or a lower cost plan terminates or closes to enrollment during the taxable year.

(7) *Examples.* The following examples illustrate the rules of this paragraph (f). Unless otherwise stated, in each example the plans are open to enrollment to a taxpayer or family member at the time of enrollment and are offered through the Exchange for the rating area where the taxpayer resides:

Example 1. Single taxpayer enrolls. Taxpayer M is single, has no dependents and enrolls in a qualified health plan. Under paragraph (f)(1)(i) of this section, M's applicable benchmark plan is the second lowest cost silver plan providing self-only coverage for M.

Example 2. Family enrolls. The facts are the same as in *Example 1*, except that M, her spouse N, and their dependent enroll in a qualified health plan. Under paragraphs (f)(1)(ii) and (f)(2) of this section, M's and N's applicable benchmark plan is the second lowest cost silver plan covering M, N, and their dependent.

Example 3. Single taxpayer enrolls with non-dependent. Taxpayer O is single and resides with his daughter, K, but may not claim K as a dependent. O purchases family coverage for himself and K. Under paragraphs (f)(1)(i)(A) and (f)(1)(i)(C) of this section, O's applicable benchmark plan is the second lowest cost silver plan providing self-only coverage for O. However, K may qualify for a premium tax

credit if K is otherwise eligible. See paragraph (h) of this section.

Example 4. Single taxpayer enrolls with dependent and nondependent. The facts are the same as in *Example 3*, except that O also resides with his teenage son, L, and claims L as a dependent. O purchases family coverage for himself, K, and L. Under paragraphs (f)(1)(ii) and (f)(2) of this section, O's applicable benchmark plan is the second lowest cost silver plan covering O and L.

Example 5. Children only enroll. The facts are the same as in *Example 4*, except that O enrolls only K and L in the coverage. Under paragraph (f)(1)(i)(C) of this section, O's applicable benchmark plan is the second lowest cost silver plan providing self-only coverage for L.

Example 6. Applicable benchmark plan unrelated to coverage purchased. Taxpayers P and Q, who are married, reside with Q's two teenage daughters, M and N, whom they claim as dependents. P and Q purchase self-only coverage for P and family coverage for Q, M, and N. Under paragraphs (f)(1)(ii) and (f)(2) of this section, P's and Q's applicable benchmark plan is the second lowest cost silver plan covering P, Q, M, and N.

Example 7. Change in coverage family. Taxpayer R is single and has no dependents when she enrolls in a qualified health plan for 2014. On August 1, 2014, R has a child, O, whom she claims as a dependent for 2014. R enrolls in a qualified health plan covering R and O effective August 1. Under paragraph (f)(1)(i) of this section, R's applicable benchmark plan for January through July is the second lowest cost silver plan providing self-only coverage for R. Under paragraphs (f)(1)(ii) and (f)(2) of this section, R's applicable benchmark plan for the months August through December is the second lowest cost silver plan covering R and O.

Example 8. Minimum essential coverage for some coverage months. Taxpayer S claims his daughter, P, as a dependent. S and P enroll in a qualified health plan for 2014. S, but not P, is eligible for government-sponsored minimum essential coverage for September to December 2014. Thus, under paragraph (c)(1)(iii) of this section, January through December are coverage months for P and January through August are coverage months for S. Because, under paragraphs (d) and (f)(1) of this section, the premium assistance amount for a coverage month is computed based on the applicable benchmark plan for that coverage month, S's applicable benchmark plan for January through August is the second lowest cost silver plan under paragraphs (f)(1)(ii) and (f)(2) of this section covering S and P. Under paragraph (f)(1)(i)(C) of this section, S's applicable benchmark plan for September through December is the second lowest cost silver plan providing self-only coverage for P.

Example 9. Family member eligible for minimum essential coverage for the taxable year. The facts are the same as in *Example 8*, except that S is not eligible for government-sponsored minimum essential coverage for any months and P is eligible for government-sponsored minimum essential coverage for the entire year. Under paragraph (f)(1)(i)(C) of this section, S's applicable benchmark plan is the second lowest cost silver plan providing self-only coverage for S.

Example 10. Qualified health plans not covering certain families. (i) Taxpayers V and W are married and live with W's mother, K, whom they claim as a dependent. The Exchange for their rating area offers self-only and family coverage at the silver level through Issuers A, B, and C, who each offer only one silver level plan. Issuers A and B respectively charge V and W a monthly premium of \$900 and \$700 for family coverage, but do not allow individuals to enroll a parent in family coverage. Issuers A and B respectively charge \$600 and \$400 for self-only coverage for K. Issuer C offers a qualified health plan that provides family coverage for V, W, and K under one policy for a \$1,200 monthly premium. Thus, the Exchange offers the following silver level options for covering V's and W's coverage family:

Issuer A: \$1,500 for premiums for two policies (\$900 for V and W, \$600 for K)

Issuer B: \$1,100 for premiums for two policies (\$700 for V and W, \$400 for K)

Issuer C: \$1,200 for premiums for one policy (\$1,200 for V, W, and K)

(ii) Because some silver level qualified health plans for family coverage offered on the Exchange do not cover all members of their coverage family under one policy, under paragraph (f)(3) of this section, the premium for V's and W's applicable benchmark plan may be the premium for a single policy or for more than one policy. The coverage offered by Issuer C is the second lowest cost silver level option for covering V's and W's family. The premium for their applicable benchmark plan is the premium for the Issuer C coverage.

Example 11. (i) The facts are the same as in *Example 10*, except that Issuer B covers V, W, and K under one policy for a premium of \$1,100, and Issuer C does not allow individuals to enroll parents in family coverage. Issuer C charges a monthly premium of \$700 for family coverage for V and W and a monthly premium of \$500 for self-only coverage for K. Thus, the Exchange offers the following silver level options for covering V's and W's coverage family:

Issuer A: \$1,500 for premiums for two policies (\$900 for V and W, \$600 for K)

Issuer B: \$1,100 for premiums for one policy (\$1,100 for V, W, and K)

Issuer C: \$1,200 for premiums for two policies (\$700 for V and W, \$500 for K)

(ii) The coverage offered by Issuer C is the second lowest cost silver level option for covering V's and W's family. The premium for their applicable benchmark plan is the premiums for the two policies available through Issuer C.

Example 12. Family members residing in different locations. [Reserved]

Example 13. Qualified health plan closed to enrollment. Taxpayer Y has two dependents, R and S. Y, R, and S enroll in a qualified health plan. The Exchange for the rating area where the family resides offers silver level plans J, K, L, and M, which are the first, second, third, and fourth lowest cost silver plans covering Y's family. When Y's family enrolls, Plan J is closed to enrollment. Under paragraph (f)(5) of this section, Plan J is disregarded in determining Y's applicable benchmark plan, and Plan L is Y's applicable benchmark plan.

Example 14. Benchmark plan closes to new enrollees during the year. (i) Taxpayers X, Y, and Z each have coverage families consisting of two adults. In the rating area where X, Y, and Z reside, Plan 2 is the second lowest cost silver plan and Plan 3 is the third lowest cost silver plan covering the two adults in each coverage family offered through the Exchange. The X and Y families each enroll in a qualified health plan that is not the applicable benchmark plan (Plan 4) in November during the annual open enrollment period. Plan 2 closes to new enrollees the following June. Thus, on July 1, Plan 3 is the second lowest cost silver plan available to new enrollees through the Exchange. The Z family enrolls in a qualified health plan in July.

(ii) Under paragraphs (f)(1), (f)(2), and (f)(6) of this section, the applicable benchmark plan is Plan 2 for X and Y for all coverage months during the year. The applicable benchmark plan for Z is Plan 3, because Plan 2 is not open to enrollment through the Exchange when the Z family enrolls.

Example 15. Benchmark plan terminates for all enrollees during the year. The facts are the same as in *Example 14*, except that Plan 2 terminates for all enrollees on June 30. Under paragraphs (f)(1), (f)(2), and (f)(6) of this section, Plan 2 is the applicable benchmark plan for X and Y for all coverage months during the year, and Plan 3 is the applicable benchmark plan for Z.

(g) *Applicable percentage—(1) In general.* The applicable percentage multiplied by a taxpayer's household income determines the taxpayer's required share of premiums for the benchmark plan. This required share is subtracted from the adjusted monthly premium for the applicable benchmark plan when computing the premium assistance amount. The applicable percentage is computed by first determining

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the percentage that the taxpayer's household income bears to the Federal poverty line for the taxpayer's family size. The resulting Federal poverty line percentage is then compared to the income categories described in the table in paragraph (g)(2) of this section (or successor tables). An applicable percentage within an income category increases on a sliding scale in a linear manner and is rounded to the nearest one-hundredth of one percent. The ap-

plicable percentages in the table may be adjusted in published guidance, see § 601.601(d)(2) of this chapter, for taxable years beginning after December 31, 2014, to reflect rates of premium growth relative to growth in income and, for taxable years beginning after December 31, 2018, to reflect rates of premium growth relative to growth in the consumer price index.

(2) *Applicable percentage table.*

Household income percentage of Federal poverty line	Initial percentage	Final percentage
Less than 133%	2.0	2.0
At least 133% but less than 150%	3.0	4.0
At least 150% but less than 200%	4.0	6.3
At least 200% but less than 250%	6.3	8.05
At least 250% but less than 300%	8.05	9.5
At least 300% but less than 400%	9.5	9.5

(3) *Examples.* The following examples illustrate the rules of this paragraph (g):

Example 1. A's household income is 275 percent of the Federal Poverty line for A's family size for that taxable year. In the table in paragraph (g)(2) of this section, the initial percentage for a taxpayer with household income of 250 to 300 percent of the Federal poverty line is 8.05 and the final percentage is 9.5. A's Federal poverty line percentage of 275 percent is halfway between 250 percent and 300 percent. Thus, rounded to the nearest one-hundredth of one percent, A's applicable percentage is 8.78, which is halfway between the initial percentage of 8.05 and the final percentage of 9.5.

Example 2. (i) B's household income is 210 percent of the Federal poverty line for B's family size. In the table in paragraph (g)(2) of this section, the initial percentage for a taxpayer with household income of 200 to 250 percent of the Federal poverty line is 6.3 and the final percentage is 8.05. B's applicable percentage is 6.65, computed as follows.

(ii) Determine the excess of B's Federal poverty line percentage (210) over the initial household income percentage in B's range (200), which is 10. Determine the difference between the initial household income percentage in the taxpayer's range (200) and the ending household income percentage in the taxpayer's range (250), which is 50. Divide the first amount by the second amount:

$$210 - 200 = 10$$

$$250 - 200 = 50$$

$$10/50 = .20$$

(iii) Compute the difference between the initial premium percentage (6.3) and the sec-

ond premium percentage (8.05) in the taxpayer's range; $8.05 - 6.3 = 1.75$.

(iv) Multiply the amount in the first calculation (.20) by the amount in the second calculation (1.75) and add the product (.35) to the initial premium percentage in B's range (6.3), resulting in B's applicable percentage of 6.65:

$$.20 \times 1.75 = .35$$

$$6.3 + .35 = 6.65.$$

(h) *Plan covering more than one family—(1) In general.* If a qualified health plan covers more than one family under a single policy, each applicable taxpayer covered by the plan may claim a premium tax credit, if otherwise allowable. Each taxpayer computes the credit using that taxpayer's applicable percentage, household income, and the benchmark plan that applies to the taxpayer under paragraph (f) of this section. In determining whether the amount computed under paragraph (d)(1) of this section (the premiums for the qualified health plan in which the taxpayer enrolls) is less than the amount computed under paragraph (d)(2) of this section (the benchmark plan premium minus the product of household income and the applicable percentage), the premiums paid are allocated to each taxpayer in proportion to the premiums for each taxpayer's applicable benchmark plan.

(2) *Example.* The following example illustrates the rules of this paragraph (h):

Example. (i) Taxpayers A and B enroll in a single policy under a qualified health plan. B is A's 25-year old child who is not A's dependent. B has no dependents. The plan covers A, B, and A's two additional children who are A's dependents. The premium for the plan in which A and B enroll is \$15,000. The premium for the second lowest cost silver family plan covering only A and A's dependents is \$12,000 and the premium for the second lowest cost silver plan providing self-only coverage to B is \$6,000. A and B are applicable taxpayers and otherwise eligible to claim the premium tax credit.

(ii) Under paragraph (h)(1) of this section, both A and B may claim premium tax credits. A computes her credit using her household income, a family size of three, and a benchmark plan premium of \$12,000. B computes his credit using his household income, a family size of one, and a benchmark plan premium of \$6,000.

(iii) In determining whether the amount in paragraph (d)(1) of this section (the premiums for the qualified health plan A and B purchase) is less than the amount in paragraph (d)(2) of this section (the benchmark plan premium minus the product of household income and the applicable percentage), the \$15,000 premiums paid are allocated to A and B in proportion to the premiums for their applicable benchmark plans. Thus, the portion of the premium allocated to A is \$10,000 ($\$15,000 \times \$12,000/\$18,000$) and the portion allocated to B is \$5,000 ($\$15,000 \times \$6,000/\$18,000$).

(i) [Reserved]

(j) *Additional benefits*—(1) *In general.* If a qualified health plan offers benefits in addition to the essential health benefits a qualified health plan must provide under section 1302 of the Affordable Care Act (42 U.S.C. 18022), or a State requires a qualified health plan to cover benefits in addition to these essential health benefits, the portion of the premium for the plan properly allocable to the additional benefits is excluded from the monthly premiums under paragraph (d)(1) or (d)(2) of this section.

(2) *Method of allocation.* The portion of the premium properly allocable to additional benefits is determined under guidance issued by the Secretary of Health and Human Services. See section 36B(b)(3)(D).

(3) *Examples.* The following examples illustrate the rules of this paragraph (j):

Example 1. (i) Taxpayer B enrolls in a qualified health plan that provides benefits in addition to the essential health benefits the

plan must provide (additional benefits). The monthly premium for the plan in which B enrolls is \$385 (Amount 1), of which \$35 is allocable to the additional benefits. The premium for B's applicable benchmark plan is \$440, of which \$40 is allocable to the additional benefits. The excess of the premium for B's applicable benchmark plan over B's \$60 contribution amount (which is the product of B's household income and the applicable percentage) is \$380 per month (Amount 2).

(ii) Under this paragraph (j), the premium for the qualified health plan in which B enrolls and the applicable benchmark premium each is reduced by the portion of the premium that is allocable to the additional benefits provided under that plan. Therefore, Amount 1 is reduced to \$350 ($\$385 - \35), the premium for B's applicable benchmark plan is reduced to \$400 ($\$440 - \40), and Amount 2 is reduced to \$340 ($\400 less \$60). B's premium assistance amount for a coverage month is \$340, the lesser of Amount 1 and Amount 2.

Example 2. (i) The facts are the same as in *Example 1*, except that B's applicable benchmark plan provides no benefits in addition to the essential health benefits required to be provided by the plan. Thus, under paragraph (j) of this section, only the amount of the monthly premium for the plan in which B enrolls is reduced by the portion of the premium that is allocable to the additional benefits provided under that plan, and Amount 1 is \$350 ($\$385 - \35). The premium for B's applicable benchmark plan is not reduced under this paragraph (j), and Amount 2 is \$380 ($\$440 - \60). B's premium assistance amount for a coverage month is \$350, the lesser of these two amounts.

(k) *Pediatric dental coverage*—(1) *In general.* For purposes of determining the amount of the monthly premium a taxpayer pays for coverage under paragraph (d)(1) of this section, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii) of the Affordable Care Act (42 U.S.C. 13031(d)(2)(B)(ii)) (a stand-alone dental plan), the portion of the premium for the stand-alone dental plan that is properly allocable to pediatric dental benefits that are essential benefits required to be provided by a qualified health plan is treated as a premium payable for the individual's qualified health plan.

(2) *Method of allocation.* The portion of the premium for a stand-alone dental plan properly allocable to pediatric dental benefits is determined under guidance issued by the Secretary of Health and Human Services.

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(3) *Example.* The following example illustrates the rules of this paragraph (k):

Example. (i) Taxpayer C and C's dependent, R, enroll in a qualified health plan. The premium for the plan in which C and R enroll is \$7,200 (\$600/month) (Amount 1). The plan does not provide dental coverage. C also enrolls in a stand-alone dental plan covering C and R. The portion of the premium for the dental plan allocable to pediatric dental benefits that are essential health benefits is \$240 (\$20 per month). The excess of the premium for C's applicable benchmark plan over C's contribution amount (the product of C's household income and the applicable percentage) is \$7,260 (\$605/month) (Amount 2).

(ii) Under this paragraph (k), the amount C pays for premiums (Amount 1) for purposes of computing the premium assistance amount is increased by the portion of the premium for the stand-alone dental plan allocable to pediatric dental benefits that are essential health benefits. Thus, the amount of the premiums for the plan in which C enrolls is treated as \$620 for purposes of computing the amount of the premium tax credit. C's premium assistance amount for each coverage month is \$605 (Amount 2), the lesser of Amount 1 (increased by the premiums allocable to pediatric dental benefits) and Amount 2.

(1) *Families including individuals not lawfully present—(1) In general.* If one or more individuals for whom a taxpayer is allowed a deduction under section 151 are not lawfully present (within the meaning of § 1.36B-1(g)), the percentage a taxpayer's household income bears to the Federal poverty line for the taxpayer's family size for purposes of determining the applicable percentage under paragraph (g) of this section is determined by excluding individuals who are not lawfully present from family size and by determining household income in accordance with paragraph (1)(2) of this section.

(2) *Revised household income computation—(i) Statutory method.* For purposes of paragraph (1)(1) of this section, household income is equal to the product of the taxpayer's household income (determined without regard to this paragraph (1)(2)) and a fraction—

(A) The numerator of which is the Federal poverty line for the taxpayer's family size determined by excluding individuals who are not lawfully present; and

(B) The denominator of which is the Federal poverty line for the taxpayer's family size determined by including individuals who are not lawfully present.

(ii) *Comparable method.* The Commissioner may describe a comparable method in additional published guidance, see § 601.601(d)(2) of this chapter.

[T.D. 9590, 77 FR 30385, May 23, 2012; 77 FR 41048, July 12, 2012]

§ 1.36B-4 Reconciling the premium tax credit with advance credit payments.

(a) *Reconciliation—(1) Coordination of premium tax credit with advance credit payments—(i) In general.* A taxpayer must reconcile the amount of credit allowed under section 36B with advance credit payments on the taxpayer's income tax return for a taxable year. A taxpayer whose premium tax credit for the taxable year exceeds the taxpayer's advance credit payments may receive the excess as an income tax refund. A taxpayer whose advance credit payments for the taxable year exceed the taxpayer's premium tax credit owes the excess as an additional income tax liability.

(ii) *Responsibility for advance credit payments.* A taxpayer must reconcile all advance credit payments for coverage of any member of the taxpayer's family. If advance credit payments are made for coverage of an individual for whom no taxpayer claims a personal exemption deduction, the taxpayer who attests to the Exchange to the intention to claim a personal exemption deduction for the individual as part of the determination that the taxpayer is eligible for advance credit payments for coverage of the individual must reconcile the advance credit payments.

(iii) *Advance credit payment for a month in which an issuer does not provide coverage.* For purposes of reconciliation, a taxpayer does not have an advance credit payment for a month if the issuer of the qualified health plan in which the taxpayer or a family member is enrolled does not provide coverage for that month.

(2) *Credit computation.* The premium assistance credit amount is computed on the taxpayer's return using the taxpayer's household income and family